# The Retina Care Center, LLC

## Patient Information

Patient's Name: ___________________________________________________ Date: ________________
(First) (MI) (Last) Month/Day/Year

Date of Birth: ________________ Age: ____ Social Security No.: _______________________(Optional)
Month/Day/Year

Sex: Male Female (Circle One) Marital Status: Single Married Widowed Divorced (Circle One)

Home Phone: (____) ______________ Work Phone: (____) ____________Cell Phone: (___) _____________

Street Address: ___________________________________________________________________________

City: _____________________________________________ State: ________ Zip Code: ____________

Email: __________________________________ Employer/Occupation: ______________________________

Preferred Method of Contact: Phone: __ Home __Cell __ Work, Other Method: ____________________

Preferred Spoken Language: ___ English Other: _________________________________

Ethnicity: ___Hispanic or Latino ___ Not Hispanic or Latino

Race: ___ American Indian or Alaska Native ___Asian ___Black or African American
___Native Hawaiian or other Pacific Islander ___White or Caucasian

Spouse/Parent Name: _______________________________________________________________________

Date of Birth: ________________________ Social Security Number: _________________________(Optional)

Home Phone: (____) ________ Work Phone: (____) ______________ Cell Phone: (___) _______________

Employer: _________________________________________________________________________________

## Authorization to Disclose Health Information

Please list persons you authorize to receive and discuss information regarding your personal health information (medical, surgical, and billing), if any:

Name: ______________________________________________ Relationship: ______________________

Phone Number: ________________________________ Alternate Number: ________________________

Is this person your Power of Attorney for medical purposes? Yes No (Circle One)

## Insurance Information

Primary Insurance: ________________________________________________________________________

Policy Holder: _________________________________ Relationship: _________________________________

Secondary Insurance: ______________________________________________________________________

Policy Holder: _________________________________ Relationship: _________________________________

I hereby authorize **The Retina Care Center, LLC** to bill my insurance company (which may include release of medical information to process the claim). I also authorize payment to be made directly to **The Retina Care Center, LLC**. I agree to pay any balances and/or charges when billed for medical services rendered and accept responsibility for any balances and/or charges, not covered by insurance or if uninsured for the patient named above. I certify that I have examined the above information and that it is true, accurate and complete to the best of my knowledge.

Signature:_____________________________________________________ Date:_________________________

# THE RETINA CARE CENTER

## NEW PATIENT QUESTIONNAIRE

**Name:** ______________________________ **Birth Date:** ____________

**Contact Person:** ________________ **Phone:** ______________ **Cell:** ____________

**Optometrist/Ophthalmologist:**________________________ **Phone:** ______________

**Address** (if known):______________________________ **Fax #:** ______________

**Family Doctor/Internist:** ________________________ **Phone:** ______________

**Address** (if known): ______________________________ **Fax #:** ______________

**What is the main ocular reason for your visit today? Please describe the problem:**

________________________________________________________________

________________________________________________________________

**Have you ever had or are you currently having any of the following eye problems?**

**Please Check all that apply – Thank You!**

| YES | | RIGHT/DATE | LEFT/DATE |
|---|---|---|---|
| ☐ | Cataract Surgery | | |
| ☐ | Other Eye Surgery | | |
| ☐ | Glaucoma | | |
| ☐ | Loss, Distorted or Fluctuating Vision | | |
| ☐ | Loss of Side Vision | | |
| ☐ | Flashes of Light | | |
| ☐ | Floaters | | |
| ☐ | Eye Injury | | |
| ☐ | Double Vision | | |
| ☐ | Eye Pain or Soreness | | |
| ☐ | Glare/Light Sensitivity | | |
| ☐ | Macular Degeneration | | |
| ☐ | Retinal detachment | | |
| ☐ | Laser Treatment | | |
| ☐ | Other (Please Specify) | | |

Patient's Name: ______________________________

## REVIEW OF SYSTEMS

**Please check all that apply:**

| Yes | | Please Elaborate (When, Type) |
|---|---|---|
| ☐ | Diabetes | How long? |
| ☐ | Problems with Your Endocrine System (Pancreas, Thyroid) | |
| ☐ | High Blood Pressure | How long? |
| ☐ | Heart Problems (Heart Attack or Disease) | |
| ☐ | Do you have a pacemaker or defibrillator? | |
| ☐ | Circulation Problems | |
| ☐ | Problems with your Blood or Excessive Bleeding | |
| ☐ | Pulmonary/Breathing Problems (Lung Disease, Asthma, Emphysema) | |
| ☐ | Stroke | |
| ☐ | Cancer – What Kind? | |
| ☐ | Liver Disease (Hepatitis, Jaundice) | |
| ☐ | Depression | |
| ☐ | Hay Fever/Sinus problems | |
| ☐ | Recent Fever or Weight Loss | |
| ☐ | Digestive Problems, or Changes to Bowel Habits | |
| ☐ | Urinary Problems | |
| ☐ | Neurologic Problems (Numbness, Seizures, Paralysis) | |
| ☐ | Muscle or Joint Problems (Arthritis, etc.) | |
| ☐ | Skin problems (Rashes, Excessive Dryness) | |
| ☐ | Problems with your Immune System | |
| ☐ | AIDS / HIV | |

## CURRENT MEDICATIONS

**Please list all medications you take, including eye drops:**

| Name | Dosage (mg) | How Often | | Name | Dosage (mg) | How Often |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**Do you take aspirin (Excedrin, Anacin, etc.)?** ☐ No ☐ Yes If yes, how much? ______________________________

**Patient Name** ___________________________________

## SURGICAL HISTORY – PLEASE LIST ALL SURGERIES PERFORMED IN THE LAST **10** YEARS

| SURGERY | DATE | SURGEON | | SURGERY | DATE | SURGEON |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**Have you ever had any ANESTHETIC COMPLICATIONS?** ☐ No ☐ Yes If Yes, please explain:

_____________________________________________________________________________

## ALLERGIES

Are you allergic to any medications? ☐ No ☐ Yes If yes, please list name and reaction (Use back of page if needed).

_____________________________________________________________________________

_____________________________________________________________________________

## FAMILY HISTORY

**Do any of your family members have :**

| Yes | No | | Relationship to Patient |
|---|---|---|---|
| ☐ | ☐ | Retinal Detachment | |
| ☐ | ☐ | Glaucoma | |
| ☐ | ☐ | Macular Degeneration | |
| ☐ | ☐ | Blindness | |
| ☐ | ☐ | Diabetes | |

## SOCIAL HISTORY

Occupation (prior to retirement, if retired) ______________________________________________

Smoke? ☐ No ☐ Yes If yes, how much? ___________ ☐ Former Smoker

Alcohol ? ☐ No ☐ Yes If yes, how much? ___________

Driving? ☐ No ☐ Yes If no, when did you stop? ___________

## ADVANCED DIRECTIVES

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Do you have a living will or other legal documents pertaining to life support or quality of care if you become incapacitated due to illness or injury? |

**History Review:** _________________________________________ **Date:** ___________________________

Physician's Signature

# NOTICE OF PRIVACY PRACTICES SUMMARY
## Acknowledgement of Receipt

This is only a summary of our Notice of Privacy Practices. Please review the full Notice to learn how we use and disclose medical information about you and your rights concerning these uses and disclosures. The full Notice is available upon request.

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

**Treatment, Payment, and Health Care Operations.** We may use your PHI in order to provide your medical care; to bill for our services and to collect payment from you or your insurance company; and for the general operation of our business.

**Appointment Reminders.** We may use and disclose medical information to contact you as a reminder that you have an appointment or that you should schedule an appointment. If you are not home, we may leave this information in a telephone message or a message left with the person answering the phone.

**Marketing, Fundraising, and Sale of Protected Health Information (PHI).** We will obtain your prior written authorization before sending you certain marketing communications. We may use or disclose your demographic information in order to contact you for our fundraising activities, but you have the right to opt out of such communications. We will not sell your health information without your prior written authorization.

**We may use your PHI as otherwise authorized or required by law for such purposes as:**

- public health reporting and oversight activities
- judicial, administrative, or law enforcement proceedings
- complying with workers' compensation laws
- communicating with your family or caregivers

INDIVIDUAL RIGHTS REGARDING MEDICAL INFORMATION

**You have the right to:**

- Request certain restrictions on our use and disclosure of your PHI
- Request communications from us by specific means or locations
- Inspect and copy your medical record
- Ask us to correct the information in your medical record
- Receive an accounting of disclosures of your PHI by our practice
- Be notified in the case of a breach of unsecured PHI

**I have reviewed the Summary of Notice of Privacy Practices and acknowledge that a copy of the full Notice of Privacy Practices will be provided to me upon request. I understand my rights regarding my protected health information and hereby authorize The Retina Care Center to obtain or release all pertinent information regarding my medical care as described in the HIPAA Compliant Notice of Privacy Practices. This authorization remains in effect until revoked.**

_______________________________________________

Print Patient Name

_______________________________________________ ___________________________________

Signature of Patient or Responsible Party Date